

Division of Health Care Facilities

|   |  |  |  |
|---|--|--|--|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>TN2603</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____ | (X3) DATE SURVEY<br>COMPLETED<br><br><b>10/08/2014</b> |
|---|--|--|--|

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

**WILLOWS AT WINCHESTER CARE & REHABIL**

**32 MEMORIAL DRIVE  
WINCHESTER, TN 37398**

| (X4) ID<br>PREFIX<br>TAG | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE |
|--------------------------|--|---------------------|--|--------------------------|
| N 000                    | Initial Comments<br><br>A licensure survey was conducted from October 6, 2014, through October 8, 2014, at Willows At Winchester Care & Rehabilitation Center. No deficiencies were cited under Chapter 1200-8-6, Standards for Nursing Homes. | N 000               |  |                          |

Division of Health Care Facilities

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

STATE FORM

0899

DFC411

If continuation sheet 1 of 1